DOCUMENT RESUME

ED 330 191 EC 300 163

AUTHOR Sundram, Clarence J.
TITLE Serving Medically Frail Individuals: Five Case Studies of Deaths of Residents of the Terence Cardinal Cooke Health Care Center.
INSTITUTION New York State Commission on Quality of Care for the Mentally Disabled, Albany.; New York State Mental Hygiene Medical Review Board, Albany.
PUB DATE Sep 90
NOTE 45p.
PUB TYPE Reports - Descriptive (141)

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS Adults; Attendants; Case Studies; *Death; *Developmental Disabilities; Long Term Care; *Medical Care Evaluation; Medical Case Histories; Medical Services; Needs Assessment; Outcomes of Treatment; Residential Care; *Residential Institutions; *Severe Disabilities; Special Health Problems
IDENTIFIERS *Medically Fragile; Terence Cardinal Cooke Health Care Center NY

ABSTRACT

The deaths of five resident clients at the Terence Cardinal Cooke Health Care Center (New York), a residential program for profoundly impaired and medically fragile individuals with developmental disabilities, in March and April of 1989 were investigated. Methods of study included examination of medical records from the Cooke Center and other sites where clients were treated, autopsy reports, and interviews with site staff and administrators. The report presents an overview of the Cooke Center and its population, findings from each case study, conclusions, and recommendations. The report reveals problems in: the timely ordering of diagnostic tests and transfers to acute care facilities; routine monitoring and documentation of clients' health status; coordination and communication among staff to ensure proper management of clients experiencing acute medical problems; infection control; and critical self-examination and corrective action when deaths occurred. Appendices include responses to a draft of the report from the facility and the New York State Office of Mental Retardation and Developmental Disabilities. (PB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED330191

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

EC 300163

BEST COPY AVAILABLE

"PERMISSION TO REPRODUCE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY

Gary W. Maslow

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

rving Medically Frail Individuals:

ive Case S of Deaths of dents of the Terence Cardinal Cooke Health Care Center

©1990 Commission on Quality of Care for the Mentally Disabled

Serving Medically Frail Individuals:
Five Case Studies of Deaths of Residents of the Terence Cardinal Cooke Health Care Center

A Report

by the New York State Commission on Quality of Care
for the Mentally Disabled
and the Mental Hygiene Medical Review Board

Clarence J. Sundram

Irene L. Platt
James A. Cashen
COMMISSIONERS

September 1990

Preface

The Commission offers this report as an opportunity for providers to reflect upon the challenges presented by medically frail clients with whose care they have been entrusted, and the adequacy of their response to these clients' special needs.

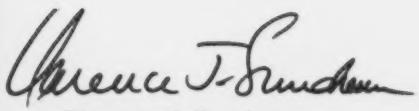
Approximately 150 developmentally disabled children and adults reside in the Terence Cardinal Cooke Health Care Center. The severity of these clients' developmental disabilities and the complexity of their medical needs distinguish the Center as being the largest facility in New York State, if not the country, serving such a profoundly impaired and medically-fragile population. While many other private sector programs and State Developmental Centers serve similarly disabled persons, none serves so many.

This report of five case studies of Cardinal Cooke Center residents who died in 1989 demonstrates the unique and challenging needs of this frail population and describes the areas in which vigilance in attending to these needs requires improvement.

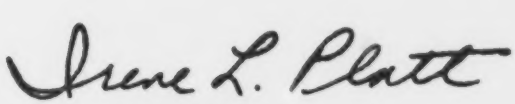
Review of the five deaths by the Commission on Quality of Care for the Mentally Disabled and the Mental Hygiene Medical Review Board revealed problems in the timely ordering of diagnostic tests and transfers to acute care facilities; routine monitoring and documentation of clients' health status; coordination and communication among staff to ensure proper management of clients experiencing acute medical problems; infection control; and critical self-examination and corrective action—through the Mortality Review process—when deaths occurred.

The report also presents the recommendations offered by the Commission and Board which the facility agreed to implement.

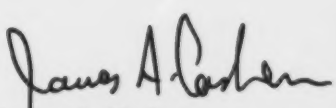
Recognizing that many programs throughout the State serve children and adults similar to those served by the Terence Cardinal Cooke Health Care Center, although perhaps not in the same numbers, the Commission offers this report as an opportunity for providers to reflect upon the challenges presented by medically frail clients with whose care they have been entrusted, and the adequacy of their response to these clients' special needs.



Clarence J. Sundram
Chairman



Irene L. Platt
Commissioner



James A. Cashen
Commissioner

Staff Acknowledgements

Project Director
Thomas R. Harmon

Investigators:
Anne Budin
Patricia Sherman

Production Staff
Irene Douglas
Marcus Gigliotti
Jacalyn Guay
Anne Harrienger

Table of Contents

Introduction 1

Chapter I: Overview 2

Chapter II: Case Studies 4

Lisa Cartwright 4

Liana Poe 9

Tawana Adams 12

Doris Sanchez 15

Shaban DeJesus 18

Chapter III: Conclusions and Recommendations 22

Appendix:

Responses from:
The Terence Cardinal Cooke Health Care Center
The Office of Mental Retardation and Developmental Disabilities

Introduction

Reasons for Review

In the summer of 1989, the Commission on Quality of Care for the Mentally Disabled and the Mental Hygiene Medical Review Board initiated an investigation into the deaths of five residents of the Terence Cardinal Cooke Health Care Center who expired in March and April of that year.

Three of the clients—Lisa Cartwright, Liana Poe and Tawana Adams—resided in the Center's Intermediate Care Facility (ICF) and the remaining two individuals—Doris Sanchez and Shaban DeJesus—were residents of the Center's Specialty Hospital.[1] The investigation into four of the deaths was prompted by the Commission's policy of closely scrutinizing the deaths of all children in residential care. These four children ranged from four and one-half to 17 years of age. The scope of the investigation, however, was expanded to include a review of Lisa Cartwright's death at the age of 31 upon the Commission's receipt of complaints concerning her care.

Methods

The investigation included a review of medical records from the Cardinal Cooke Center, as well as from acute care hospitals to which several clients were transferred prior to death. Autopsy reports were also reviewed in those cases where autopsies were performed. Beyond the record reviews, Commission staff made several site visits to the Center during which interviews were conducted with the medical director; physicians primarily responsible for each client; directors and/or coordinators of nursing, respiratory therapy and infection control; and nursing and direct care staff who had knowledge of the clients and/or events proximate to the times of the deaths.

This report summarizes the findings, conclusions and recommendations stemming from the investigation. Chapter One presents an overview of the Terence Cardinal Cooke Center and its population. On a case-by-case basis, findings pertaining to each client's care and death are offered in Chapter Two. The conclusions and recommendations of the Commission and Medical Review Board are presented in Chapter Three. The facility's response to a draft copy of the report, as well as the Office of Mental Retardatation and Developmental Disabilities' response are reprinted in the Appendix.

1 The names of all individuals appearing in the report are pseudonyms.

Chapter I: Overview

The Terence Cardinal Cooke Health Care Center is a multi-faceted facility specializing in long-term care for a variety of medically needy persons. Several floors of the complex, which was formerly Flower Fifth Avenue Hospital, house a Skilled Nursing Facility for elderly people, a Skilled Nursing Facility for persons with Acquired Immune Deficiency Syndrome, an End-Stage Renal Dialysis Unit and a Developmental Disabilities Clinic which schedules 40,000 outpatient visits a year.

The Center also operates two residential programs for approximately 150 developmentally disabled persons: a Specialty Hospital, certified to serve 50 clients; and an Intermediate Care Facility (ICF), certified to serve 102 residents.

Specialty Hospital

The Specialty Hospital is a unique class of facility in the OMRDD continuum of care. . . charged primarily with providing necessary services to ameliorate health care problems so that its clients can be transitioned to programs . . .required to provide adequate medical and nursing services to meet the clients' needs and establish and maintain necessary relationships with external health care providers.

The Specialty Hospital is a unique class of facility in the Office of Mental Retardation and Developmental Disabilities (OMRDD) continuum of care. It is intended to serve as a transitional setting for clients with developmental disabilities, and its mission is the prevention, amelioration or limitation of health care problems which prevent the placement of clients in less restrictive environments, such as ICF's, community residences, and foster or family care homes.

Whereas other programs certified by OMRDD focus on increasing all aspects of a developmentally disabled client's functioning, the Specialty Hospital is charged primarily with providing necessary services to ameliorate health care problems so that its clients can be transitioned to programs where their total needs can be addressed more "holistically." The Specialty Hospital is required to provide adequate medical and nursing services to meet the clients' needs and establish and maintain necessary relationships with external health care providers, such as general hospitals, laboratories, and clinics.

The Cardinal Cooke Specialty Hospital employs two full-time physicians for Monday through Friday daytime coverage. Evening, nighttime and weekend physician coverage is provided by a pool of five to six doctors who work part-time for the facility. The Specialty Hospital also receives physician coverage by virtue of an affiliation with Metropolitan Hospital which permits its pediatric residents to rotate through the Cardinal Cooke facility. Nursing coverage for the Specialty Hospital consists of five nurses on all shifts. The direct care staff-to-client ratio is one-to-four.

Intermediate Care Facility

Initially, when the Cardinal Cooke facility began operations in the early 1980's, the entire service dedicated to developmentally disabled clients was certified as a Specialty Hospital. However, as clients became medically stable, they were deemed no longer in need of a Specialty Hospital level of care; yet, there were limited placement options open to these clients. Thus in 1988, the fourth and fifth floors of the facility, which today house 102 clients, were converted to an ICF level of care.

Within the OMRDD continuum of service, the ICF care modality is envisioned as either a long-term or transitional setting whose goal is to provide clients with a combination of services that will promote maximal development of skills and enable them to live as independently as their handicapping conditions will allow. The services to be offered by an ICF directly, or through contract with other agencies, are intended to address the total needs of clients, not solely the medical needs; they include health related services (i.e., medical, dental, nursing, etc.), social services, psychological services and training, and self-care and habilitation services.

The services to be offered by an ICF directly, or through contract with other agencies, are intended to address the total needs of clients, not solely the medical needs; they include health related services (i.e., medical, dental, nursing, etc.), social services, psychological services and training, and self-care and habilitation services.

The Cardinal Cooke ICF employs two half-time physicians, one deployed to each floor of the ICF, to monitor and address the medical needs of the clients. These physicians work daytime hours, Monday through Friday, and, if emergencies occur at other times, a physician can be summoned from the Specialty Hospital service or the client can be sent to an outside hospital. While the direct care staff-to-client ratio on both ICF floors is one-to-four, nursing coverage on the two floors differs, reflecting the variance in client needs. The fourth floor ICF, which serves approximately 50 clients, utilizes four nurses on day and evening shifts and two nurses on night shifts. This floor serves a generally younger population and clients who were recently transitioned out of the Specialty Hospital. The fifth floor ICF carries two nurses on most shifts.

In addition to health related staff, the Cardinal Cooke Center employs a variety of professional and para-professional staff to train and assist clients in skills of daily living and other habilitative activities.

Clientele

The residents of the Cardinal Cooke Center are among the most disabled in OMRDD's service system in terms of the severity of their developmental disabilities, number and complexity of medical conditions, and need for medical interventions. Ranging in age from six months to more than forty years, most are non-ambulatory, non-verbal, suffer seizure disorders and function in the profound range of mental retardation. Many require gastric or naso-gastric tube feedings, frequent positioning and aggressive respiratory therapy.

The residents of the Cardinal Cooke Center are among the most disabled in OMRDD's service system in terms of the severity of their developmental disabilities, number and complexity of medical conditions, and need for medical interventions.

According to OMRDD staff, the Center is unique in the State, and possibly the country, in that, while many programs may serve similarly disabled persons, none serves so many.

Chapter II: Case Studies

The following case studies present the findings of the Commission and Medical Review Board concerning the deaths of five Cardinal Cooke Center residents. Lisa Cartwright, Liana Poe and Tawana Adams were residents of the Center's ICF. Doris Sanchez and Shaban DeJesus were residents of the Center's Specialty Hospital. Each case study presents, first, a brief history of the client and the events leading to death. This is followed by the issues of concern raised by the Commission and Board in reviewing the client's care.

Lisa Cartwright

Brief History and Events Leading to Death

Lisa Cartwright was a 31-year-old resident of the Cardinal Cooke Center who died on March 22, 1989. She was diagnosed as having profound mental retardation, microcephaly and spastic quadriplegia with kyphoscoliosis and multiple contractures. She weighed 67 pounds, required total care, and had a history of seizure activity dating back to shortly after her birth.

Early Years

Ms. Cartwright's history included long-term residency for her developmental disabilities at both the Willowbrook Developmental Center and the Gouverneur Hospital. Lisa was admitted to the Mental Retardation Institute at the Flower Fifth Avenue Hospital (which later became the Cardinal Cooke Health Care Center) in November of 1978. Her last recorded seizures were in 1980.

In June of 1988, Lisa was transferred to the newly-established ICF at the Cardinal Cooke Health Care Center.

Lisa's course in the Cardinal Cooke ICF was without acute medical problems until February of 1989. On February 14, Lisa developed a fever of 102 degrees, for which she was examined by a physician who ordered Tylenol and Dimetapp, and recommended that fluids be encouraged.

Lisa continued to run a low-grade temperature for several more days, which elevated once again to 102.2 degrees on February 25. At this time, she was seen by a physician who documented an essentially negative physical examination, as well as an assessment that the cause of the fever was assumed to be viral.

Persistent Fever

Throughout most of early March, Lisa was febrile with temperatures ranging from 101 to 103.4 degrees. Several Cardinal Cooke physicians were notified of the client's persistent fever. However, no febrile work-up

nor culture of any kind was ordered until March 6, when a culture for respiratory syncytial virus (RSV) was ordered. On March 8, the client's primary physician wrote orders for 1:1 care for 48 hours, as well as a progress note discussing the relative merits of initiating Amantadine antiviral drug therapy. (It was never, in fact, administered).

On March 10, the culture for RSV was determined to be positive, and isolation procedures were initiated. Nursing progress notes from March 10 through March 18 indicate that the client received a greater than usual proportion of direct care staff time (i.e., while the usual staff ratio was 1:4, Lisa was maintained on 1:2 or 1:3 care).

From March 10 through March 14, Lisa's temperature remained intermittently febrile in the range of 101 to 104 degrees. On March 15, the first physician's orders for lab work were noted since the March 6 RSV culture. Orders were written for CBC, differential and absolute WBC count. The physician's progress notes for March 15 indicate that a chest x-ray was part of the planned intervention, but no corresponding physician's order for a chest x-ray appeared in the order sheets.

Dehydration

On March 17, the physician documented clinical signs of dehydration, including pallor and sunken eyes, in addition to Lisa's continuing fever. He ordered repeat blood work if the temperature rose above 102 degrees. His progress notes recommended "force fluids by mouth," although a corresponding order for the same did not appear.

On March 18 at 4:45 P.M., a different physician documented that he had examined Lisa, and was aware of her fever and apparent weight loss. He wrote that the results of the chest x-ray, which was planned on March 15, were not back yet.

Transfer

Later the same day, another physician documented that Lisa's temperature had once again spiked to 104 degrees, and that, in addition to her clinical dehydration, she appeared to be experiencing a moderate amount of respiratory distress. Due to his concern regarding the possibility of lung consolidation, this physician arranged for Lisa's transfer to acute care at Metropolitan Hospital.

Upon arrival at the Metropolitan Hospital Emergency Room during the evening of March 18, the examining physicians were concerned about the unusual findings of Lisa's admission chest x-ray, on which bowel loops seemed to be apparent in the left lung field. The possibility of diaphragmatic hernia was entertained. The patient was seen by medical, surgical, and thoracic consultants who were unable to determine from either chest x-ray or chest CT scan whether the intrathoracic pathology was due to bowel loops or to necrotic lung secondary to RSV disease. Lisa was admitted to the medical service for further observation and treatment.

Terminal Event

On March 21, Lisa developed cyanosis and acute respiratory distress requiring emergency intubation. The thoracic consultant examining her post-intubation x-rays noted the high probability of the colon in her chest

and recommended emergency surgical intervention despite the extremely high risk. An emergency exploratory laparotomy was performed on March 21 with negative findings: the diaphragm was intact. Consequently, Lisa's post-operative diagnosis was lung abscess vs. cystic lung. Lisa was transferred to the Medical Intensive Care Unit for post-operative care with a Swan-Ganz catheter and dopamine drip due to severe hypotension (85/50).

There Lisa experienced an episode of bradycardia which culminated in a full respiratory arrest. After 23 minutes of unsuccessful resuscitation efforts, the patient was pronounced dead at 12:38 A.M. on March 22. No autopsy was performed at the family's request and the cause of death was listed on the death certificate as cardiac arrest, due to cardiogenic shock, as a consequence of bilateral pneumonia.

Issues of Concern:

Lack of timely febrile work-up

While the client's temperature spiked to 102 degrees on February 14, 1989, and again to 102.5 on February 25, 1989, no lab work beyond an RSV culture was ordered until March 15, 1989.

Lack of a baseline chest x-ray exam

Although the progress notes of March 15, 1989 indicate a planned chest x-ray, no corresponding order for a chest x-ray appeared in the medical record. Although the responsible physician, when interviewed, stated he remembers having written this order, the facility did not have any record of an x-ray requisition, nor were any negatives on file in the Radiology Department, according to the facility's General Counsel. It appears the planned chest x-ray of March 15, 1989 was, thus, never performed.

Question of Amantadine therapy

Although the client never actually received a dose, Ms. Cartwright's physician wrote orders for, and then cancelled orders for Amantadine therapy on March 9, 1989. The physician, when interviewed, explained that he was advised to place Lisa on a trial of Amantadine upon the suggestion of the Assistant Medical Director at the Cardinal Cooke Center, who was in charge of the Center's AIDS unit, and who had extensive experience in treating lung disease. However, the physician also discussed the matter with the Center's Medical Director, whose subspeciality was pulmonary disease.

The Medical Director, when interviewed, explained that Amantadine is used primarily on type A influenza viral infections and to treat parkinsonian syndrome, and that its efficacy in RSV-type viral infections had not been established. Thus, the decision was made to defer treatment with Amantadine.

The Commission and members of the Mental Hygiene Medical Review Board expressed concern that the matter of this client's persistent fever did not appear to have been discussed with an infectious disease consul-

tant. No evidence of an infectious disease consultation was found in the medical record.

The Commission was also concerned that the medical record showed no documentation that the client was evaluated for a trial of the antiviral drug effective in the treatment of RSV, Ribavirin. Additionally, members of the Mental Hygiene Medical Review Board expressed concern that the initiation of antibiotic therapy did not appear to have been considered in the management of Lisa's case.

Lack of aggressive treatment of dehydration

Physicians' and nurses' progress records of March 14-17 made note of this client's increasing pallor and the sunken appearance of her eyes, despite the oral fluid intake which nursing staff was encouraging. The physicians involved, when interviewed, explained that IV fluids cannot be administered in the ICF units at Cardinal Cooke. The Commission and members of the Mental Hygiene Medical Review Board expressed concern that Lisa was not considered for transfer to an acute level of care sooner on the basis of her need for intravenous hydration.

Lack of coordination of Lisa Cartwright's care

When interviewed, Lisa's physician explained that he was responsible for all residents of the fifth floor ICF unit, although he is employed part-time by the Cardinal Cooke facility. He explained that his responsibilities entail performing a monthly medical evaluation on all his patients. He elaborated that he was not responsible for daily rounds or daily notes on his ICF patients. Thus, he seldom communicated with on-call night and weekend physicians regarding problems which may have occurred or had been brought to their attention, and he rarely read their progress notes. The physician further explained that he relied primarily on the daytime head nurse's daily report of matters which required his attention.

It was entirely possible, then, that the physician was unaware of the elevated temperatures his patient was experiencing during February which occurred during the evening hours. This physician's monthly summary for February 1989 made note of only one febrile episode. It also noted that on March 4, the date the summary apparently was written, Lisa was still febrile. The physician's assessment was that Lisa was experiencing "febrile illness of unknown etiology." Yet, there were no attempts at determining the etiology of the fever until March 6, when an RSV culture was ordered. The Commission and members of the Mental Hygiene Medical Review Board found the ordering and performance of appropriate diagnostic lab evaluations to have been less than timely in Lisa Cartwright's case, and reflective of less-than-adequate coordination of care by her primary physician.

Documentation practices at the Cardinal Cooke ICF

Both medical and nursing administrators at the Cardinal Cooke Center explained that medical and nursing staff are required to document only a monthly summary on clients in the ICF; there is no requirement for more frequent charting unless there is an episode of acute illness.

It appears that this documentation practice was followed quite literally in Lisa's case in which there is minimal charting after her transfer to the ICF in June of 1988. This practice made it very difficult to determine the client's baseline status at any given time in her care in the ICF previous to her acute illness of February 1989. This was due in part to the vague and incomplete nature of the monthly summaries, particularly the medical summaries in which "no change" and "nothing new" notations were frequent.

The Commission and Mental Hygiene Medical Review Board found the documentation practices of both medical and nursing services at the Cardinal Cooke ICF, as demonstrated in the Cartwright case, to be less than desirable, or even adequate, to ensure quality care.

Inadequate Mortality Review Process

The facility's Mortality Review Committee noted that, in the weeks prior to her death, Lisa had been "culture positive for RSV, but otherwise medically stable." In the Commission's opinion, this misrepresented the fact that throughout that time Lisa was intermittently febrile to 103 – 104 degrees, refractory to Tylenol and nursing cooling measures (such as tepid sponges and increased oral fluids), and that she was becoming progressively dehydrated. Although the Mortality Review Committee recommended a chest x-ray earlier in the client's course, no mention was made of the lack of a febrile work-up earlier in the client's care.

The Mortality Review Committee focused on an apparent delay in the lab's reporting of the March 16, 1989 WBC results, rather than asking why a WBC was not drawn *earlier* than March 16. The Mortality Review also focused more on Lisa's care at Metropolitan Hospital, rather than on her care at Cardinal Cooke.

In sum, it appeared that the Cardinal Cooke Center's Mortality Review process in the Cartwright case was less than adequate, as it failed to examine critical issues in her care.

Care at Metropolitan Hospital

Lisa's care at Metropolitan Hospital during the four days immediately prior to her death was also discussed by the Commission's Medical Review Board members. Although some members of the Board questioned whether it was reasonable to have brought this patient to emergency surgery on March 21 to rule out a diaphragmatic hernia only to find that it was intact, other members noted that the appropriate specialists from radiology and thoracic surgery services had been consulted regarding this decision. The consensus of the Commission and the Mental Hygiene Medical Review Board was that the decision to perform surgery in Lisa's case appeared to have been a considered clinical judgment taken as a life-saving measure.

Liana Poe

Brief History and Events Leading to Death

Liana Poe was a ten-year-old resident of the Cardinal Cooke ICF at the time of her April 17, 1989 death. She weighed 55 pounds and her height was less than three feet. Her diagnoses included profound mental retardation, static encephalopathy secondary to perinatal hypoxia, spastic quadriplegia with scoliosis and a stabilized seizure disorder.

Early Years

Liana's serious medical condition dates back to her birth in February 1979, when she was delivered by forceps extraction with vacuum assistance due to facial presentation. She reportedly had a low Apgar score and required intubation and ventilatory assistance. Within 24 hours of birth, she developed seizures. She was gradually weaned off the respirator, and, when her condition stabilized, was transferred to the New York Foundling Hospital for extended care.

During her stay at New York Foundling Hospital, her course included occasional episodes of seizures and aspiration pneumonia, as well as orthopedic surgery—an adductor tenotomy—in July 1983. She was transferred for long-term care to the Specialty Hospital of the Cardinal Cooke Center in April of 1985.

Liana's course at Cardinal Cooke Center also included recurrent episodes of aspiration pneumonia, as well as otitis media. During an acute care hospitalization in August 1985 at Metropolitan Hospital for aspiration pneumonia, she was additionally diagnosed with gastroesophageal reflux. Subsequently, she was admitted to Westchester County Medical Center in October 1985 for Nissen fundoplication and insertion of a gastrostomy feeding tube.

Recent Illnesses

In June 1986, Liana was readmitted to Metropolitan Hospital with possible intestinal obstruction, which eventually was ruled out.

Additional acute care hospitalizations during Liana's stay at Cardinal Cooke included the following:

- May 1987: admission to Our Lady of Mercy Hospital for a febrile work-up which revealed both aspiration pneumonia and otitis media.
- July 1987: readmission to Our Lady of Mercy Hospital for otitis media and hypernatremic dehydration.
- December 1987: hospitalization for pneumonia.

By June of 1988, Liana's medical condition had sufficiently stabilized to allow her to qualify for care in the Cardinal Cooke ICF.

Liana was again diagnosed with otitis media in January of 1989, and was successfully treated at Cardinal Cooke with a ten-day course of Amoxicillin. Subsequent other minor medical problems documented from January through April 1989 included notations regarding topical treatments to recurrent pressure sores of her right heel and right earlobe.

Respiratory Distress Incident

On April 14, 1989, a registered nurse on the 3-11 shift documented the following incident, which occurred on the same evening Liana had been seen by a physician for an abrasion on her left heel: At 8:30 P.M. the "client had an episode of respiratory distress due to excessive hyperextension of head. Oxygen administered..... effective..... color returned." The note indicated that the physician was notified and it is documented that from 9-11 P.M. Liana's condition remained satisfactory with good color and no further evidence of respiratory distress.

Although the nurse documented that a physician was notified regarding this incident of respiratory distress, no corresponding physician's progress note appears for April 14, 1989 beyond the note regarding the physician's assessment of the pressure ulcer on the left heel.

When interviewed, the nurse stated she could not remember whether the client was examined by the physician or not after she notified him. The physician, upon interview, stated he examined the client, but, since his findings were negative, he felt no note was necessary. No further physicians' progress notes appear until the terminal event. However, nursing progress notes document no respiratory distress on the night shift on April 14, 1989.

Terminal Event

The next nursing progress note is written three days later on the morning of Liana's death. On April 17, 1989, the day shift nursing note describes Liana as "awake, alert ... no distress noted this shift." By the evening shift (3:30 P.M.) on April 17, 1989, no change in status was documented and the client was described again as "awake, alert, color good, no respiratory distress noted." Again, the 8:00 P.M. note states: "no acute distress noted."

However, at 9:40 P.M. on April 17, the nursing progress note describes the circumstances surrounding the terminal event: "Was called to see client by client attendant, client was found lying in prone position in bed, head elevated on pillow. Client appeared pale, unresponsive, body warm to touch, extremities mottled." The note continues to describe that a "code blue" was called and full resuscitative measures administered, including cardiopulmonary resuscitation, oxygen and intravenous medications.

A physician responding to the "code blue" pronounced the client dead at 10:03 P.M. on April 17, 1989. The Medical Examiner's Office, upon autopsy, ruled that the death was natural and due to anoxic encephalopathy, due to neonatal sepsis as a consequence of maternal diabetes.

Issues of Concern:

Lack of follow-up of respiratory distress incident

From medical record documentation and from interviews of the involved staff, it appears that little, if any, follow-up occurred after Liana's episode of respiratory distress on April 14, 1989. Although her physician was notified of the incident by nursing staff, he stated his findings after examining the patient did not warrant his writing a progress note. Nursing staff documented having monitored the client for respiratory distress only

during the shift immediately following the incident. The absence of documentation by either medical or nursing staff tends to support the conclusion that no further follow-up of the client's respiratory status occurred.

The Commission and Mental Hygiene Medical Review Board believed that a complete work-up of the client's respiratory status, or possibly an assessment of the client's neurological status for break-through seizures, in an acute care setting may have been a more appropriate response to the incident of respiratory distress on April 14, 1989.

Documentation practices

The aforementioned lack of both medical and nursing notes during the period April 14 - April 17, 1989 demonstrates the inadequacy of a charting policy which requires documentation *only* in the event of acute illness for clients in the ICF (beyond the monthly charting requirements). Additionally, a review of this client's medical records in general revealed monthly medical summaries which failed to give sufficient information regarding the client's current medical status. Large lapses in progress notes by both medical and nursing staff, sometimes as long as several months, made it difficult to ascertain this client's medical and nursing care status during the months prior to her sudden expiration on April 17, 1989.

Thus, the Commission found the documentation practices of both medical and nursing services, as demonstrated in the Poe case, to be inadequate.

Inadequate Mortality Review Process

The Mortality Review Committee's summarization of the client's course immediately prior to her death omits entirely any mention of the incident of respiratory distress on April 14, 1989 and states, "the patient had been medically stable and entirely without apparent problems right up until the time of her death on April 17, 1989." Apparently, the Mortality Review Committee neither felt that this incident bore any relationship to the terminal event, nor found the incident problematic in the patient's overall course. The Commission and Mental Hygiene Medical Review Board did not concur, and found absence of follow-up of this documented incident of respiratory distress an issue of concern.

Tawana Adams

Brief History and Events Leading to Death

At the time of her April 1, 1989 death, Tawana Adams was a 14-year-old resident of Cardinal Cooke's ICF. She was diagnosed as having profound mental retardation, cerebral palsy, spastic quadriplegia, and a seizure disorder.

Early Years

Tawana's multiple medical problems date to her birth when congenital neurological damage was apparent. She suffered a respiratory arrest in her infancy, which necessitated a lengthy acute care hospitalization at Jamaica Hospital, with eventual transfer to the Long Island Jewish Hospital.

During her stay at Long Island Jewish, gastroesophageal reflux was diagnosed, and subsequently addressed surgically with Nissen fundoplication and placement of a gastrostomy feeding tube on October 1, 1985. Two days after this procedure, Tawana again suffered a respiratory arrest. She was intubated and maintained on a ventilator for an extended period due to difficulties with extubation. As a consequence of this prolonged intubation, Tawana developed upper airway obstruction necessitating a permanent tracheostomy on October 18, 1985.

By January 1986, Tawana's medical condition had stabilized, and she was accepted by the Specialty Hospital of the Cardinal Cooke Health Care Center for long-term care.

Frequent Medical Problems

Tawana's course at Cardinal Cooke was marked by frequent episodes of upper airway congestion as well as feeding problems. A brief summary of these episodes is as follows:

- March 1987: episode of pneumonia, responding to antibiotics per gastrostomy.
- April 1987: recurrence of pneumonia, again resolved by antibiotics per gastrostomy.
- May 1987: episodes of vomiting.
- July 1987: increased episodes of vomiting with another incidence of pneumonia, successfully treated with intravenous antibiotics and continuous feedings via gastrostomy.
- May 1988: increased vomiting with fever necessitating transfer to St. Vincent's Hospital where diagnoses of vomiting secondary to gastrostomy tube obstruction and pneumonia were made.

Also at this time, Tawana developed keloid scar tissue around the tracheostomy stoma, and required steroid injections to the site by a dermatologist. By June of 1988, Tawana's medical condition had sufficiently stabilized to permit transfer to Cardinal Cooke's ICF.

Tawana Adams was residing at the Cardinal Cooke ICF in March of 1989 in relatively stable medical condition. Her primary medical problems consisted of the management of intermittent episodes of emesis, which

generally responded well to cutting back her bolus gastrostomy feedings of Isocal 120 cc every three hours to half strength feedings or Pedialyte feedings at 40 cc per hour continuously. Occasional fevers associated with upper respiratory infections during this period responded well to Tylenol and sponge baths.

Final Days

On March 23, 1989, Tawana's respiratory secretions were sent for respiratory syncytial viral culture due to suspected RSV infection. The next day, she was ordered on isolation precautions with good hand washing by staff. By March 31, 1989, the results of the viral culture were obtained, and were determined positive for RSV. On the same day, Tawana experienced an episode of vomiting a large amount of her 6:00 A.M. feeding, during which staff observed a concurrent episode of cyanosis. Tawana was suctioned via her tracheostomy for a large amount of yellow-colored secretions. Oxygen was administered by the respiratory therapist with slight relief of cyanosis noted. A physician was notified.

He ordered feedings changed to Pedialyte 120 cc every three hours to run over one hour for the next twelve hours. The physician also ordered oxygen therapy continued via tracheostomy collar at 2-3 liters/minute for the next 24 hours, and observation for further respiratory distress. At this point in time (i.e., during the night shift on March 31, 1989), Tawana was running a low-grade temperature of 100.5 - 100.6 rectally.

By 8:30 A.M. on April 1, 1989, Tawana was noted to have an elevated temperature of 103.5, with brown-colored secretions obtained during suctioning of the tracheostomy tube. The physician was again notified of the patient's status, and Tylenol was administered by nursing staff.

At 9:30 A.M. on April 1, Tawana was noted to have once again developed respiratory distress. A second physician was notified, and arrangements were then initiated to transfer Tawana to an acute care facility for further evaluation and treatment. During the process of making these arrangements, however, the patient went into full cardiopulmonary arrest at 10:10 A.M.

A code was called with two physicians responding. Epinephrine was administered intracardiac as well as through the tracheostomy, as was Atropine. Tawana was then transported to Metropolitan Hospital Pediatric Emergency Services by ambulance attendants who continued CPR en route.

At Metropolitan, more Epinephrine was given via the tracheostomy, as well as two attempts at cardioversion. An IV was finally established via surgical cutdown at 11:10 A.M., and another dose of medications delivered. Throughout these resuscitative measures, the patient remained unresponsive with dilated pupils, and was pronounced dead at 11:30 A.M. No autopsy was performed and the cause of death was listed as cardiac respiratory arrest.

Issue of Concern:

Documentation practices

The record review in this case, as in the Cartwright and Poe cases, revealed the same overall paucity of information.

The monthly medical summaries, from January through March 1989, were minimally completed and gave little indication of the client's medical status for each respective month. While the monthly nursing summaries were somewhat more detailed, progress notes for both services demonstrated large gaps. For example, there had been no medical progress note for three months prior to the charting regarding the terminal event. As in all ICF cases reviewed, it was difficult to discern this client's baseline medical and nursing status during the period immediately prior to death from the minimal documentation available.

Doris Sanchez:

Brief History and Events Leading to Death

Doris Sanchez was a four-year, ten-month-old girl at the time of her March 23, 1989 death. She was diagnosed as having, among other conditions, profound mental retardation, spastic quadriplegia, a seizure disorder, chronic respiratory congestion and a history of gastrointestinal bleeding and vomiting.

Early Years

Doris' multiple medical problems date to her infancy. Born healthy, Doris' growth and development were normal until age 10 months, when she was diagnosed as having meningitis. She subsequently developed right-sided focal seizures requiring intubation.

An initial CAT scan showed right-sided cerebral edema and infarct; later, a repeat CAT scan showed symmetrical hydrocephalus. A ventriculo-peritoneal shunt was placed at Columbia-Presbyterian Hospital. Doris was initially placed in the Cardinal Cooke Health Care Center in 1985. She resided in the Specialty Hospital and her course of care was marked by frequent respiratory and ear infections. She also had several episodes of recurrent gastrointestinal bleeding.

While at the Cardinal Cooke Center, Doris had Nissen fundoplication surgery three times due to gastroesophageal reflux. The GE reflux also necessitated the surgical insertion of a gastrostomy feeding tube. Her course of care was also marked by intermittent brief seizure activity, with subsequent neurology consults and measurement of anti-convulsant medication levels, along with readjustment of her medications. Most notably, this seizure activity and medication titration occurred during December 1988 through February of 1989.

Recent Illnesses . . . Interventions

Later in February 1989, Doris was noticed to be developing fevers of 104 – 105 degrees. Blood work and urine cultures, as well as a chest x-ray, were done. Tylenol, sponge baths and a hypothermia blanket were measures taken to relieve the fever. Due to findings of white blood cells in the urine, a presumptive diagnosis of urinary tract infection was made and IV Cefuroxime (Zinacef) begun. On February 24, 1989, the medical progress notes document that Doris was transferred to St. Vincent's Hospital Emergency Room for "surgical clearance."

Upon interview, the Cardinal Cooke physician clarified that by "surgical clearance" she meant to have Doris evaluated by the St. Vincent's surgical service to rule out an acute surgical abdomen. This physician had also ordered x-rays at Cardinal Cooke prior to the transfer to St. Vincent's and ruled out the possibility that Doris might have kidney stones. The doctor felt that Doris, although non-verbal, was demonstrating signs of acute abdominal discomfort.

The progress notes at St. Vincent's Hospital indicate that Doris was admitted on February 24, 1989, and remained an inpatient until March 15, 1989. The medical progress notes of this St. Vincent's Hospital admission also indicate that Doris received a complete work-up for her persistent

fever, with all cultures and tests yielding negative results. She was discharged back to Cardinal Cooke on March 15, 1989 still febrile, with a diagnosis of "central hyperthermia." However, the Cardinal Cooke Center physician noted that Doris had no previous history of fevers of central origin.

Upon return to the Cardinal Cooke Center, the readmitting physician consulted with the treating physician at St. Vincent's, as well as Cardinal Cooke's Infectious Disease consultant, and decided to discontinue antibiotic therapy, since no focus of infection could be isolated. Follow-up lab and x-ray studies were ordered on March 16, 1989. The patient continued to be febrile at this time.

Another chronic problem Doris Sanchez demonstrated during this period was abnormally low phosphorus and calcium, and abnormally high liver function tests, including an unusually high alkaline phosphatase. To evaluate these chronically abnormal findings, a consultation was arranged with the Endocrinology Clinic at St. Vincent's Hospital for March 20, 1989.

On March 18, 1989, Doris was noted to have developed an acute problem of generalized edema, and daily weights were begun. Additionally, a urinalysis was performed to assess possible acute renal problems. On March 19, Doris had a fever of 102 degrees. A right otitis media was diagnosed, and antibiotic therapy re-initiated.

On March 20, 1989, Doris was sent back to St. Vincent's for her scheduled endocrinology consultation. Her physician documented in the medical progress notes that the St. Vincent's endocrinologist was asked to admit Doris for further evaluation of her acutely ill status, particularly in view of upcoming scheduled renal and gallium scans. St. Vincent's staff concurred with the need for this readmission.

Doris Sanchez' final admission to St. Vincent's Hospital from March 20 until her death on March 23 included multiple baseline lab and x-ray studies with a presumptive diagnosis of "hypophosphatemia, rule out rickets." She once again developed a high temperature of 105.3 degrees on March 22, and demonstrated persistent generalized edema. On March 23 at approximately 1:00 A.M., Doris went into respiratory arrest. She was successfully intubated and resuscitated, placed on a ventilator, and transferred to the Pediatric Intensive Care Unit.

Later that same day, at approximately 1:55 P.M., Doris went into cardiac arrest. Despite immediate chest compressions, emergency medications, including two doses of lidocaine, and two attempts at cardioversion, the patient remained in asystole, and was pronounced dead at 2:20 P.M. No autopsy was performed.

Issue of Concern

Overall, the Commission and Board believed that Doris Sanchez received appropriate and timely care. Doris' management intermittently required consultation with multiple pediatric subspecialists, including neurologists, surgeons, infectious disease specialists and endocrinologists. The

Commission and Mental Hygiene Medical Review Board concluded that Doris received the appropriate consultations in a timely manner, and that the primary physician adequately coordinated Doris' care. It was also found that St. Vincent's Hospital had performed a reasonable evaluation during the February 24th admission, so that Doris' discharge back to Cardinal Cooke while still febrile was not determined to be either inappropriate or premature.

The Mortality Review by the Cardinal Cooke Center, however, was somewhat limited. The Mortality Review did not articulate that the client had been admitted to St. Vincent's Hospital prior to the March 20 admission during which she expired. The only reference in the Mortality Review Committee minutes to the fact that Doris had been acutely ill, treated and released by St. Vincent's seems to be a reference that "the patient had been suffering febrile illnesses somewhat refractory to management during the weeks prior to her death ..." This statement minimizes the acuity of the client's status earlier in February, when she was febrile with temperatures of 104 – 105 degrees and required the February 24 – March 15 admission to St. Vincent's. It also omits discussion of whether the client's needs at that time were well responded to, which, in the Commission's opinion, they were.

Shaban DeJesus

Brief History and Events Leading to Death

Shaban DeJesus was a 17 year old resident of Cardinal Cooke's Specialty Hospital who was diagnosed as having profound mental retardation, spastic quadriplegia and a seizure disorder.

Early Years

Shaban was admitted to the Specialty Hospital on May 31, 1979. His medical problems at that time consisted of a history of recurrent gastrointestinal bleeding, as well as frequent respiratory infections and chronic congestion.

Apparently Shaban's medical condition stabilized sufficiently to permit his transfer from Specialty Hospital status to the Center's ICF in 1988. However, on June 3, 1988, Shaban was admitted to St. Clare's Hospital for pneumonia, as well as for a work-up of his chronic gastrointestinal problems. An endoscopy was performed, and a gastrostomy tube placed for feeding purposes. At this time, a diagnosis of chronic arthritis was also made. Later that month, Shaban was treated at St. Clare's Emergency Room for suspected gastrointestinal bleeding. Otitis media was also diagnosed. Subsequently, Shaban was transferred back to the Specialty Hospital.

Due to Shaban's history of recurrent gastrointestinal bleeding and problems with vomiting, admission was arranged, in August 1988, to Metropolitan Hospital for a Nissen fundoplication. He remained hospitalized at Metropolitan until November of 1988. His subsequent course at the Cardinal Cooke Specialty Hospital consisted of significantly fewer episodes of vomiting, GI bleeding and congestion after this procedure was performed.

March 1989

On March 7, 1989, Shaban became febrile. Due to the incidence of several other cases of respiratory syncytial virus at Cardinal Cooke, the examining physician suspected a viral etiology and ordered an RSV culture. The suspicion was confirmed on March 16, according to the medical progress notes, when the culture was determined positive for RSV. Concurrently, Shaban was noted to have a ruptured abscess of the right earlobe. Consequently, the physician ordered a ten-day course of Dicloxacillin antibiotic therapy per gastrostomy tube. Additionally, the medical progress notes indicate that isolation precautions due to RSV and the right earlobe abscess were in effect on March 19, 1989, although no physician's orders were found which specified the kind of isolation in effect or when these measures were initiated.

Subsequent progress notes document no further fever or respiratory symptoms until March 30, 1989. The examining physician during the day shift on March 30 noted the development of a low-grade fever of 100.1 degrees, with slight nasal congestion, but no other significant findings. By evening shift, however, a second physician noted that Shaban had developed a fever of 101.2 degrees, as well as an episode of a small amount of coffee-ground emesis occurring at about 7:10 P.M. Blood pressure at this

time was recorded by the physician as 108/70, with no other vital sign elevations. The physician ordered vital signs every two hours through the night, with specific orders to notify him "if the BP was less than 90 mm. Hg. systolic."

Additionally, the physician ordered the continuous Isocal gastrostomy feeds at 50 cc per hour be changed to Pedialyte at the same rate until the morning, with the directive that Shaban be re-evaluated by a physician at that time. Also ordered were Tylenol for the fever and blood tests in the morning.

The evening shift nursing staff began recording frequent vital signs at 7:30 P.M.; the blood pressure reading recorded was 159/105. Similarly, throughout the remaining evening and night shifts, significantly elevated blood pressures ranging from 145 – 162 over 102 – 116 were recorded. However, there was no notation that the physician on-call was informed. The night nurse recorded one further episode of coffee-ground emesis, as well as yellow-green discharge exuding from around the gastrostomy stoma. Shaban remained febrile at 102 degrees throughout the night, despite two doses of Tylenol and cold compresses.

The day shift nurse on March 31 recorded finding Shaban's abdomen distended and "boardlike" at 7:00 A.M. She documented that the continuous feeding was stopped and the physician was notified. She also informed the physician of the 8:00 A.M. blood pressure reading of 152/102, and that Shaban appeared pale and lethargic; the physician made arrangements for immediate transfer to St. Clare's Hospital.

Terminal Event

Upon arrival at St. Clare's Hospital Emergency Department at 10:15 A.M., the examining physician ordered admission blood work as well as chest and abdominal films. The medical services consultant documented bilateral lung infiltrates and suspected abdominal obstruction, with a WBC of 22.5 and hemoglobin of 16.9.

This consultant recommended Shaban's admission to rule out pneumonia, sepsis and abdominal obstruction. In preparing Shaban for admission, the emergency room physician inserted a central IV catheter into the left internal jugular vein, and began Ringer's Lactate at 80 cc/hour. At 2:15 P.M., Shaban was sent for repeat chest x-ray films to confirm the catheter's placement. More blood work was drawn, including baseline arterial blood gases at 4:10 P.M. Oxygen at 50 percent by mask was begun at 4:20 P.M. However, at 4:50 P.M., Shaban went into full respiratory arrest. Despite resuscitative efforts, Shaban remained unresponsive and was pronounced dead at 5:12 P.M. The cause of death was determined by the Medical Examiner's Office to be due to therapeutic complication: a hemothorax had occurred during the IV catheter placement at the emergency room of St. Clare's Hospital. This emergency room incident was investigated by the Department of Health which cited St. Clare's for several deficiencies in its emergency room operations.

Issues of Concern:

Nursing Judgment

During the evening and night shifts on March 30, 1989, Cardinal Cooke nursing staff consistently documented abnormal blood pressure readings for this client, but apparently failed to notify either the charge nurse or the on-call physician of these observations.

The on-call physician ordered blood pressures every two hours during the night of March 30 due to Shaban's episode of coffee-ground emesis. He stated, upon interview, that he anticipated the possibility Shaban's blood pressure might drop if Shaban were actively bleeding from the GI tract. Hence, the orders were to "call physician if BP less than 90 mm. Hg. systolic." However, the client remained *hyper*tensive rather than becoming hypotensive through the night.

The nursing staff interviewed demonstrated a clear understanding of what a normal blood pressure for Shaban should have been (i.e., 110–120 over 70–80). What could *not* be established was why nursing staff failed to notify the on-call physician when the blood pressure readings they obtained were significantly outside this normal range (i.e., 145–162 over 102–116). The Commission and Mental Hygiene Medical Review Board concluded that the evening and night nursing personnel demonstrated poor nursing judgment in failing to notify either the nurse in charge or the physician on call of these readings.

Timeliness of transfer

It is not clear why Shaban was not evaluated for immediate transfer to acute care when he first demonstrated signs and symptoms suggestive of active GI bleeding, (i.e., coffee-ground emesis) during the evening shift on March 30, 1989. The decision to observe Shaban overnight with every two hour vital signs and to conduct blood work in the morning was scrutinized. Given that Cardinal Cooke did not have the lab capability of performing immediate blood work that evening, the Commission and Mental Hygiene Medical Review Board questioned the appropriateness of the medical judgment in waiting the time interval from approximately 7:10 P.M. in the evening on March 30 until the next morning to assess whether this febrile client might also have active GI bleeding. In the opinion of the Commission and Medical Review Board, the attending physician should have sent Shaban to the hospital on the evening of March 30 rather than waiting until the morning of March 31.

Adequacy of facility's Mortality Review

In reviewing Shaban's medical course immediately prior to his transfer to acute care, the Cardinal Cooke Mortality Review noted the client had "positive cultures for respiratory syncytial virus, but was otherwise medically stable." The Review notes continue: "early morning of March 31, 1989, he was transferred to St. Clare's Hospital for *acute respiratory distress* and coffee ground vomitus." This statement omits the facts that the coffee-ground emesis actually began the evening prior to transfer, that the client was hypertensive, febrile, had a "boardlike" abdomen, and was unable to tolerate clear gastrostomy feedings, which were exuding from

around the gastrostomy stoma. It also misrepresents the rationale for transfer as "acute respiratory distress," when none was documented by the Cardinal Cooke physician in his transfer note. The physicians's transfer summary cites "marked abdominal distention," as well as the coffee-ground emesis and hypertension, as his reasons for referral.

The Cardinal Cooke Mortality Review not only misrepresents the rationale for transfer, but omits any discussion of the events immediately prior to transfer, which the Commission identified as being problematic. The Cardinal Cooke Mortality Review focused primarily on exploration of the care provided by St. Clare's, stating the Medical Examiner reported that the client's death may have been due to a "therapeutic intervention." While the events which occurred in the St. Clare's emergency room clearly warranted further follow-up, which was done by the Department of Health, the Commission and Mental Hygiene Medical Review Board believed that Cardinal Cooke did not adequately assess the care their own clinicians rendered in the hours immediately prior to the client's transfer.

Chapter III: Conclusions and Recommendations

The examination of the deaths revealed numerous deficiencies

The examination of the deaths of five residents of the Terence Cardinal Cooke Health Care Center revealed numerous deficiencies which, in the Commission and Medical Review Board's opinion, compromised the caliber of care afforded certain individuals and suggest facility-wide problems in the delivery of adequate medical services to a medically-frail and needy population.

Routine monthly nursing and/or physician summaries appeared cursory

In many cases, routine monthly nursing and/or physician summaries appeared cursory and repetitive of previous months' notations, suggesting a less-than-adequate and thorough analysis of the clients' current health status.

Failure to order timely diagnostic tests

Failure to document the findings of physical examinations

Delays in transfer to more appropriate levels of care

When clients became acutely ill, attentiveness to their needs was compromised in various ways. Among the problems noted were:

- Failure to order timely diagnostic tests;
- Failure to document the findings of physical examinations;
- Inadequate monitoring of client vital signs or inadequate responses to troubling vital signs;
- Delays in transfer to more appropriate levels of care, despite obvious signs of clients' deteriorating conditions; and
- The apparent absence of medical leadership in the ICF units in the form of a primary physician to vigorously monitor clients' conditions; to order and analyze diagnostic tests as well as the results of ongoing monitoring by nursing and other staff; and to direct the future course of the clients' treatment.

Inadequate Mortality Review

Furthermore, in the Commission's opinion, when the Cardinal Cooke Center had an opportunity to critically examine the adequacy of care delivered through the conduct of mortality reviews, it abdicated its responsibility to ensure the future well-being of its clientele and the quality of its services by failing to address obvious shortcomings in the care of clients under review. Whereas the mortality review process could have been used as an exploratory, problem-solving and educational tool, it appears to have provided cursory, limited and less-than-critical reviews, usually approving the care rendered by the facility.

Inadequate Procedures

The Commission and Board recognize that, proximate to the time of these deaths, the facility was experiencing, for the first time to its knowledge, an outbreak of RSV in epidemic proportions. This undoubtedly placed a strain on the facility's operations and health services as it endeavored to ensure isolation and follow-up of ill clients. This situation, however, also underscores the medical frailty of the facility's clientele and the need for vigorous health status surveillance and timely intervention when the status of clients falters. On the basis of the cases examined, the facility fell short of meeting this need. In fact, in August 1989 when Commission investigators visited the facility, it was observed that the facility's vigilance was less-than-adequate in maintaining the only client in residence, who was RSV positive and on contact isolation. This client, Victor, who is extremely sociable, was observed sitting in his wheelchair in a hallway. He touched facility staff, another client who was wheeled by, shared his toy and was touched by facility staff and Commission staff who shook his hand. No one intervened or advised facility staff, the other client who made contact, or Commission visitors to wash their hands after making contact, not even the staff who escorted the Commission on the tour.

Recommendations

To assure the quality of health services afforded clients and aggressive follow-up of those who are acutely ill, the Commission and Medical Review Board recommend that Terence Cardinal Cooke Health Care Center develop policies and procedures to ensure that:

- The results of all physician examinations are documented in case records.
- Routine monthly nursing and physician summaries are accurate synopses of the client's stable or changing medical status for that month and are based on a review of the client's case record, including daily notes, and, in those cases where the client has been ill during the month, a contemporaneous examination by a physician.
- Vital sign checks are conducted regularly for specified periods of time in the presence of abnormal vital signs or other signs or symptoms of illness. Guidelines should be developed which prescribe what vital sign readings should be immediately reported to a physician and what should prompt examination by a physician.
- A physician be assigned responsibility for coordinating all diagnostic and follow-up work on acutely ill clients and monitoring the client's status daily.
- The services of infectious disease specialists are available and, when indicated, are called upon promptly for consultations.

The facility should also develop quality assurance mechanisms to ensure that policies, such as those recommended above, are implemented. Toward this end, it is recommended that Quality Assurance staff periodically review a sample of records of clients who become acutely ill, or are transferred to community hospitals, to determine compliance with internal

policies. It is also recommended that Quality Assurance staff participate in the mortality review process.

It is also recommended that the facility develop a protocol for mortality reviews which encourages self-examination, outlines the issues to be addressed during review, includes participation by other departments (e.g., Quality Assurance, Nursing, etc.), in addition to physicians, and assigns responsibility for the review and presentation of a case to a physician who was not primarily responsible for care in the case.

Finally, given the past year's experience with an outbreak of RSV and the overall physical layout of the facility which necessitates congregation of clients, it is recommended that the facility retain, through the OMRDD and/or the Department of Health, the services of a consultant in infectious diseases who, through on-site review, can offer the facility advice on environmental issues which may facilitate infection control and protocols for quality assurance monitoring of infection control measures.

Appendix:

Responses from Terence Cardinal Cooke Health Care Center and Office of Mental Retardation and Developmental Disabilities

Terence Cardinal Cooke
Health Care Center

1249 FIFTH AVENUE, NEW YORK, N.Y. 10029
(212) 360-3600

ADMINISTRATION

June 22, 1990

Mr. Thomas R. Harmon
Director, Medical Review
Investigations Bureau
State of New York
Commission on Quality of Care
for the Mentally Disabled
99 Washington Ave., Suite 1002
Albany, New York 12210

Dear Mr. Harmon:

I am in receipt of the May 31, 1990 letter to Gerhard Treser, M.D., regarding Terence Cardinal Cooke Health Care Center's ("Center") February 21, 1990 response to the Commission on Quality of Care's ("Commission") November 30, 1989 draft report on the 1989 deaths of Center residents L.C., L.P., T.A., D.S. and S.D.

The Center is pleased to note the Commission's acceptance of the corrective actions proposed and initiated at the Center in response to the Commission's recommendations and the Center's own quality assurance reviews. The Center continues to refine these corrective actions and to monitor the delivery of patient care services to the developmentally disabled client population through its quality assurance mechanisms.

The Center would like to address itself specifically to those issues where there is apparent disagreement between the Commission and the Center regarding two of the five cases studied by the Commission.

With respect to the care rendered to L.C., the Center concurs with the findings of the Commission as stated in its May 31 letter.

As stated by the Commission, L.C.'s RSV test was ordered on March 6, 1989 and reported to be positive on March 10th. Upon review of Lisa's temperatures during the timeframe referenced by the Commission (i.e., early March -- March 3 to March 18), the medical record documentation indicates that L.C. had elevated temperatures every day from March 3rd to March 18th. The Center does not dispute the Commission's characterization of L.C.'s temperature during early March as persistent.

As a matter of clarification, the Center's earlier disagreement with the Commission's characterization of L.C.'s fever as persistent focused on a broader timeframe (i.e., February and March, 1989). The Center states in its initial response that L.C.'s febrile episodes did resist empiric therapy later in her medical course, leading to transfer to an acute care facility. The Center also openly acknowledges on page 4 of the letter that the attending physician's handling of L.C.'s fever during early March was not sufficiently aggressive. The Center is of the opinion that there is no real disagreement between the Commission and the Center regarding the management of L.C.'s care during the critical period of early March 1989.

The Commission has also affirmed its opinion, as stated in its November 30, 1989 draft report, as to a finding of delay in transfer of S.D for acute care medical management. Although the Commission acknowledges the Center's position that S.D was transferred to the hospital as soon as an acute abdomen was recognized on March 31, the Commission points to signs of a possible G.I. bleed and the facility's inability to conduct diagnostic tests as grounds for an earlier transfer. The Center respectfully submits that the decision made by the on-call physician at the time in question to monitor S.D.'s condition through the evening was a reasonable professional judgment based upon the physical examination findings.

The Center, however, reiterates its commitment to counselling staff concerning the general advisability of early transfer to an acute care facility of clients who evidence signs of possible incipient or developing conditions which cannot be immediately and adequately investigated with a full diagnostic work-up at the Center.

The Center is pleased that the Commission's final report of five case studies of client deaths includes an introductory overview of the Center's Specialty Hospital and ICF programs. The Commission's comments on the Center's client population as viewed within the continuum of OMRDD's service system give an appropriate context to the report which follows delineating specific problems the Center faces serving such a medically fragile population.

The Center respectfully requests, however, that the overview of the Center's programs in Chapter I of the Commission's final report, page 3, include reference to the Center's End-Stage Renal Dialysis Unit, which provides 17,000 client treatments per year, and the Developmental Disabilities Clinic, which schedules 40,000 client visits on an annual basis. Please also note that the Center's Discrete AIDS Unit is a Skilled Nursing Facility, not a Health Related Facility, as stated on page 3.

Additionally, it is recommended that the following clarifications be made in Chapter I with respect to the Center's nursing staff levels in the Specialty Hospital and fourth floor ICF: the Specialty Hospital utilizes at least five (5) nurses per shift; the fourth floor ICF utilizes at least four (4) nurses on the day and evening shifts and two (2) nurses on the night shift.

The Center looks forward to continuing a meaningful exchange on issues relating to client service with the members of the Commission on Quality of Care and the Medical Review Board, who have provided us through these case studies with constructive recommendations on improving the quality of care for our clients.

Very truly yours,

Daniel P. Leahey

Daniel P. Leahey
Director of Program Development

DPL/fj

Terence Cardinal Cooke
Health Care Center

1249 FIFTH AVENUE, NEW YORK, N.Y. 10029
(212) 360-3636

JOHN F. KEANE
PRESIDENT

February 21, 1990

Mr. Thomas R. Harmon
Executive Secretary/Director
Medical Review Investigations Bureau of
New York Commission on Quality of
Care for the Mentally Disabled
99 Washington Avenue, Suite 1002
Albany, NY 12210

Re: [redacted] Lisa
QCC ID No. 8903167

[redacted] Liana
QCC ID No. 8904108

[redacted], Tawana
QCC ID No. 8904067

[redacted] Doris
QCC ID No. 8903156

[redacted] Shaban
QCC ID No. 8903218

Dear Mr. Harmon:

Please allow this letter to serve as the response of the Terence Cardinal Cooke Health Care Center (hereinafter, "the Center"), to the recent inquiries by the Commission into the deaths of the above named patients. We have conducted internal reviews of these matters, and wish to offer the following responses and proposals to the concerns raised by the Commission.

LISA [redacted]

Lisa [redacted] was one of a number of patients at the Center's Intermediate Care Facility ("ICF") involved in an outbreak of respiratory syncytial virus (RSV) in February and March, 1989. The Commission has generally expressed concern regarding the adequacy of the work-up for periodic episodes of fever in this patient during this time. The Commission has specifically expressed concern that an infectious disease consult was not obtained; that a chest x-ray was considered but not performed; and that no antibiotic or antiviral coverage was started for this patient.

As the Commission has acknowledged, the Center's population was experiencing an outbreak of RSV of epidemic proportions as of the time in question in this case. As of February 14, 1989, this patient had tested positive for RSV. Furthermore, respiratory illnesses are generally common in our patient population, by virtue of their relative inactivity, among other factors. Low-grade fevers frequently accompany such respiratory illness. Accordingly, this patient's course was not unexpected, and she was treated in accordance with our experiences with similar patients.

Significantly, we must disagree with the Commission's finding that this patient's fever was persistent throughout the time in question. Rather, her fever was periodic, with the patient being afebrile much of the time in question. At times she experienced moderate rises in temperature, which were responsive to empiric therapy with tylenol, and cold compresses where indicated. Only very late in her course did the febrile episodes resist the empiric therapy, leading to her transfer to an acute care facility.

With regard to the issue of antibiotic or antiviral coverage, the Center offers the following response. In view of the epidemiologic and diagnostic evidence, it was appropriately considered that the patient's illness was of a viral (RSV) etiology. Accordingly, the virus would not be responsive to antibiotic therapy. The coordinating physician, Dr. Edgar Rivas, then properly considered therapy with an antiviral agent, Amantadine. Moreover, he discussed the case with both the Associate Medical Director, Dr. DiPietro, and the Medical Director, Dr. Perla. Although Dr. DiPietro felt that a trial of Amantadine might be appropriate, Dr. Perla, an expert in pulmonary diseases, pointed out that Amantadine was not documented to be effective against RSV. Accordingly, the initial plan to start a trial of Amantadine, was abandoned.

The Commission has also expressed concern that an infectious disease consult was not obtained, nor consideration given to another antiviral agent, such as Ribavirin. The Center believes it likely that in the medical judgment of Dr. Rivas, an infectious disease consult was not warranted, particularly in that the patient's course had been discussed with both Dr. DiPietro and Dr. Perla. Although Dr. Perla is not an infectious disease expert, he is an expert in pulmonary disease, and had obviously had the benefit of recently coordinating the treatment of many patients with RSV infection. Although the Center does not believe that a consult with an infectious disease expert would have significantly altered the outcome of this case, we propose to encourage our staff to generally pursue consults with appropriate specialists early in the course of a patient's illness, where in their medical judgment it is appropriate to do so. It should be noted that the Center now employs an infectious disease physician for the

Skilled Nursing Facility ("SNF") on a full-time basis, who is readily available for consults in the ICF and Specialty Hospital.

The Center acknowledges that Dr. Rivas' handling of this aspect of the patient's care was not sufficiently aggressive, and should have included input from an infectious disease specialist when the patient's course remained relatively unchanged from March 9 to March 18. The Center is committed to thorough internal investigation and censure of its staff when appropriate, and towards this end conducted a quality assurance focused review of a sample of Dr. Rivas' cases. Following this review, the Quality Assurance Committee adopted the recommendation that the matter of Dr. Rivas be referred to the Medical Board for review and appropriate action, although Dr. Rivas had already resigned from the medical staff at the Center. The Office of Professional Medical Conduct was appropriately advised of Dr. Rivas' resignation. The Center wishes to emphasize its continuing commitment, as demonstrated in the matter of Dr. Rivas, to policing its staff to ensure the highest standards of patient care.

Another specific criticism of the Commission was the failure of Dr. Rivas to insure that a chest x-ray he had recommended on March 15, 1989, was actually performed. The Center acknowledges that this was a significant failure in medical charting communication. The Center agrees to stress to our medical staff the importance of recording a request for a diagnostic test such as this as a physician's order, in the physicians' order sheets. The Center does wish to point out that even if the chest x-ray had been obtained on a timely basis, diagnosis would have been difficult, as evidenced by the patient's course at Metropolitan.

Nevertheless, this is a particularly visible example of what the Commission has identified as poor charting practices evident at the Center. While we do not believe that these charting deficiencies had any bearing on the outcome of any of these cases, we acknowledge that there has been a lapse in proper charting practice and propose to take steps to counsel all of our staff on the importance of full and complete medical record keeping. We will impress upon our staff that routine monthly nursing and physicians' summaries must be accurate synopses of the client's stable or changing medical status for that month, and should be based upon a review of the client's case record, including daily progress notes from nursing staff in cases of acute illness. We will also adopt the Commission's recommendation that in those cases where the client has been acutely ill during the month, the monthly physicians' summary include a contemporaneous examination by a physician.

The Center acknowledges that it would be helpful to define more clearly the physician's role in case management referential to the programmatic levels of care. The Medical Department of the Center is working actively to develop such parameters. It is our goal to develop standardized protocols for patient care evaluation in both the Specialty Hospital and the ICF. As these protocols are developed, it would be the role of the Center's Quality Assurance Department to monitor compliance with these protocols by medical and nursing staff.

We believe the issue of record keeping also touches on the Commission's concern that there was a lack of coordination between the primary physician, Dr. Rivas, and the other medical staff. The Center believes that by requiring more comprehensive and frequent medical charting, communication between the medical

and nursing staffs will be enhanced, and improved patient care will be the result. Accordingly, we propose to require daily nursing summaries of patients with acute illnesses. We will also adopt the Commission's recommendation that a primary physician be assigned to all acutely ill patients to vigorously monitor clients' conditions, order and analyze diagnostic tests as well as the results of ongoing monitoring by nursing and other staff, and generally direct the future course of the client's treatment.

The Commission has also expressed some concern on the quality of the mortality review process in this matter. It is respectfully submitted that the mortality review in this matter may also have been hindered by the absence of complete documentation. We are hopeful that by improving our record keeping practice, we will enable our mortality and morbidity committee to properly perform its role, which we acknowledge should be as an exploratory, problem solving, and educational body applying a critical eye to the care rendered at the Center, in order to make appropriate recommendations for improved patient care. We will also adopt the Commission's recommendations that the quality assurance staff periodically review a sample of the records of clients who become acutely ill or are transferred to community hospitals, to determine compliance with internal policies. Furthermore, we will adopt the Commission's recommendation that quality assurance staff participate in the mortality review process. Finally, we agree with the Commission's recommendation that primary responsibility for mortality review and presentation of a case be assigned to a physician who is not primarily responsible for the care in the case.

The Commission also expressed some concern that the patient was not promptly transferred to an acute care facility, when a need for I.V. hydration was identified. It is respectfully submitted that the medical records reflect that the need for hydration was initially identified at a time when in the judgment of the treating physicians the dehydration could be treated empirically by providing additional fluids by mouth. The patient continued to experience dehydration despite the additional fluids, and ultimately reached the point where I.V. rehydration was necessary, only shortly before her transfer to the acute care facility.

The Center also believes it important for the Commission to appreciate the difficulties which have historically been encountered in arranging transfer with acute care facilities. The Center has in the past noted a palpable reluctance on the part of certain acute care facilities to accept the Center's patients. In order to address this difficulty, the Center is engaged in ongoing discussions with an acute care facility in Manhattan regarding transfer of Center patients for acute care medical management. We will also continue to counsel our staff concerning the general advisability of early transfer to an acute care facility of patients with conditions which might later require more aggressive therapy than we can provide.

LIANA [redacted]

The Commission has expressed concern that there was a lack of follow-up between an April 14, 1989 episode of acute respiratory distress, and the patient's sudden death on April 17, 1989. It is respectfully submitted that the patient's case was managed properly. When the patient experienced the episode

of respiratory distress on April 14, the nurse properly advised our staff physician, Dr. Navarro, who examined the patient at the time. He found no evidence of respiratory distress on his examination, and in fact made normal findings. As the Commission is aware, Dr. Navarro did not make any note recording his examination and findings. While we do not feel that Dr. Navarro's failure to make this note had any bearing on the outcome of the case, we will henceforth require our medical staff to notate a physical examination when the exam results in findings which are within normal limits, but the exam was in response to an earlier clinically significant abnormal episode (in this case, the earlier report of some respiratory distress). In addition, Dr. Navarro will be counseled regarding his failure to record his physical examination findings.

The Commission's other concerns regarding poor charting practice and the quality of the M & M review, have also been addressed in our response to the Commission's concerns in the case of Lisa [redacted] above.

TAWANA [redacted]

The Commission expressed concern in this matter regarding the Center's record keeping practices. As we have indicated in discussing the matter of Lisa [redacted] the Center feels that while its record keeping practices have been steadily improving, there is room for further improvement, and towards that end, propose to require daily notes for nursing staff for patients with acute illness. Physician documentation practices have been discussed elsewhere in this report, and are the subject of continuing evaluation concerning the development of standardized protocols by our medical staff.

DORIS [redacted]

The Commission expressed concern that the quality of the mortality and morbidity review in this case was poor. The Center has acknowledged the Commission's concern in discussing the matter of Lisa [redacted] and respectfully refer the Commission to that section for the proposed improvements.

SHABAN [redacted]

The Commission has expressed concern that there may have been a twelve hour delay in transferring Shaban to an acute care facility, in view of an acute abdominal process. It is respectfully submitted that on the evening of March 30, the medical records clearly indicate that there was no acute abdomen at that time. On March 30, 1989, 7:30 p.m., the patient was examined by Dr. Cherrick who specifically noted that he examined the abdomen and found it soft with normal bowel sounds. He also noted that the patient had a small amount of "coffee ground" emesis, and on that basis directed the nursing staff to carefully monitor the patient's blood pressure through the evening, for signs of possible hypotension. Apparently, some time shortly before the patient was examined by the treating physician the next morning, he did in fact develop an acute abdomen, which was promptly recognized and transfer arranged.

The patient expired in the emergency room at St. Clare's Hospital, apparently secondary to the inadvertent insertion of an I.V. catheter (intended for placement into the left interval jugular vein), into the left pleural cavity, resulting in significant bleeding. Clearly the patient's demise had no relationship to the timing of the transfer from our institution. However, we will continue to counsel our staff concerning the general advisability of early

BEST COPY AVAILABLE

transfer to an acute care facility of patients with conditions which might later require more aggressive therapy than we can provide.

The Commission also expressed concern that the nursing staff did not contact Dr. Cherrick when the patient became hypertensive. Although we do not believe there is any relationship to the outcome of this matter, we agree that this was a questionable medical judgment by the nursing staff. Accordingly, we will adopt the Commission's recommendation that vital sign checks be conducted regularly for specified periods of time in the presence of abnormal vital signs or other signs for symptoms of illness. We will require our nursing staff to check blood pressure, pulse, temperature, and respiration as directed by the treating physician at a rate deemed appropriate by the treating physician in view of the severity of the underlying illness, and contact the treating physician promptly concerning any significant deviation from the normal values for the particular patient.

The Commission's other concern in this case was with regard to the quality of the mortality and morbidity review. Our proposals for improving this process have been discussed elsewhere.

Thank you for giving us the opportunity to consider these matters and make the improvements in quality of care which have been noted. I trust that our response will be deemed satisfactory, and look forward to your approval. Of course, if you have any further questions, please do not hesitate to contact the undersigned.

Very truly yours,

John F. Keane

John F. Keane

STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

44 HOLLAND AVENUE • ALBANY • NEW YORK •12229-0001

ARTHUR Y. WEBB
Commissioner

ELIN M. HOWE
Executive Deputy Commissioner

August 1, 1990

Mr. Clarence J. Sundram
Chairman
Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue
Albany, New York 12210

Dear Mr. Sundram:

The efforts of the Commission on Quality of Care to ensure that services are improved at Terence Cardinal Cooke Health Care Center (TCCHCC) are commendable. OMRDD's interest and efforts parallel those of the Commission.

The Commission on Quality of Care and OMRDD have a joint responsibility to the individuals living at TCCHCC to improve the quality of services and their quality of life.

Your report reflects the need for continued oversight and the seriousness of the problems that exist at TCCHCC.

Our current efforts, specifically a joint review with the Department of Health of medical services at TCCHCC and the hospitals the Center uses, should provide a comprehensive report on the medical services at TCCHCC. The results of this review should be available before the end of August 1990.

We will not only share the report with the responsible parties at TCCHCC but will also amend, if necessary, recent statements of deficiencies regarding the services at this program.

Our goal is to place people with developmental disabilities currently residing in TCCHCC into community-based programs. Hopefully, this can all be accomplished during 1992 and will result in these individuals receiving the appropriate services and improved quality of life that community living offers.

Sincerely,

Elin M. Howe

Elin M. Howe
Commissioner

EMH/TJC
cc: Mr. Cuite

Right at home. Right in the neighborhood.